schizophrenia. We examined this possibility by performing a record linkage (Kendrick & Clark, 1993) within the ISD database in order to identify subjects who were recorded as first admissions but had been admitted previously. The proportion of subjects correctly classified as first admissions in 1971 was 62.4% and in 1988 was 79.9%. Therefore, misclassification is present and it was worse in the earlier years. The ASR for each year between 1969 and 1988 was corrected for this misclassification and the secular trend was reanalysed. The ASR for males in 1969 was 13.6/100 000 and in 1988 was 6.7/100 000 (% annual average change: −3.0%, 95% confidence intervals −4.0% to −2.0%, $P<0.0001$). In females the 1969 ASR was 10.4/100 000 and in 1988 was 3.8/100 000 (% annual average change −4.2%, 95% confidence intervals −5.2% to −3.2%, $P<0.0001$). Comparing these figures with the unadjusted estimates given in the paper, we conclude that the observed decline is not an artefact produced by this misclassification.

The decline in the diagnosis of schizophrenia in Scotland over the last two decades is not adequately explained by changes in the age structure of the population, diagnostic practice, treatment setting, or misclassification of first admissions. It remains difficult to dismiss a genuine decline in incidence.

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JOHN R. GEDDES
ROGER J. BLACK
LAWRENCE J. WHALLEY
JOHN M. EAGLES

Department of Psychiatry
Royal Edinburgh Hospital
Edinburgh EH10 5HF

Maintenance therapy for schizophreniform disorder

SIR: Schooler (*BJP*, December 1993, **163** (suppl. 22), 58–65) illustrates the increasing research evidence in support of planning maintenance treatment after an acute episode of schizophrenia. In contrast, there is little guidance available for maintenance treatment of schizophreniform disorder (DSM–III–R), in which all symptoms of the episode must resolve within six months. Although Procci (1989) recommends withdrawing medication after an acute episode, he notes the absence of supporting data.

Schizophreniform disorder is common and has a poor prognosis. Coryell & Tsuang (1982) found that 93 out of 510 patients discharged with a diagnosis of schizophrenia could be retrospectively diagnosed as having schizophreniform disorder. Opjordsmoen (1991) found 56% of patients with a diagnosis of schizophreniform disorder proceeded to schizophrenia within 10 years. Both studies found only one-third of schizophreniform patients with a good outcome at long-term follow-up.

Such findings lead one to ask whether continuation therapy after a schizophreniform episode would reduce relapse, and whether maintenance therapy would reduce recurrence or development into schizophrenia. This hypothesis may be supported by Crow *et al* (1986), who found that the poorest relapse rates during maintenance therapy in schizophrenia occurred in those patients with a longer delay between onset and treatment.

In practice, patients with schizophreniform disorder may well receive maintenance therapy. Marengo *et al* (1991) found 50% of their sample receiving neuroleptic medication at two-year follow-up, and 44% after four years. Whereas Schooler's review reminds us of the rationale for such an approach in schizophrenia, we are unaware of any findings which answer this important question in schizophreniform disorder.

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PHILIP STOKES
MARK STEELS
ALAN LEE

Department of Psychiatry
B Floor
University Hospital
Nottingham NG7 2UH

Onset of the antidepressant effect of ECT

SIR: Scott & Whalley (*BJP*, June 1993, **162**, 725–732) explore a poorly researched area in electroconvulsive therapy (ECT). We would like to add two points to their discussion.